Baller Referral Form

Baller Dream Foundation

* Required

1. Patient First & Last Name *

2. Patient DOB *

Example: January 7, 2019

3. School / Grade/ College attending

4. Phone Number *

5. Email Address

6. Home Address *

7. Mailing Address (If different than home address)

8. Temporary Address (IF APPLICABLE)

_____

Support Information

9. Support Being Requested *
(Check all that apply)

Mark all that apply.

- [ ] Gift or Experience
- [ ] Financial Assistance (Gas/Groceries/Personal Bills)
- [ ] Medical Expenses
- [ ] Resources during treatment
- [ ] Community Support/Involvement within local area
- [ ] Other: _____

10. Has this patient been gifted by any other gifting organization(s)? *
(please note that being gifted by another organization does not exclude you from receiving support from BDF)

Mark only one box.

- [ ] Yes
- [ ] No

11. If yes, what organization(s) were they gifted by?

_____

12. Is the patient currently affiliated with another Non-Profit? *

Mark only one box.

- [ ] Yes
- [ ] No

13. If affiliated with another non-profit, Who?

_____

Parent Guardian Information

Information is only requested if Baller is under the age of 18

14. Parent/Guardian First & Last Name

_____

15. Parent/Guardian Relationship

Check all that apply.

- [ ] Mother
- [ ] Father
- [ ] Grandparent
- [ ] Adoptive Parent
- [ ] Legal Guardian
- [ ] Other: _____

16. Parent/Guardian Email

_____

17. Parent/Guardian Phone Number

_____

18. Parent/Guardian Mailing Address

_____

19. Parent/Guardian (2) First & Last Name

_____

20. Parent/Guardian (2) Relationship

Check all that apply.

- [ ] Mother
- [ ] Father
- [ ] Grandparent
- [ ] Adoptive Parent
- [ ] Legal Guardian
- [ ] Other: _____

21. Parent/ Guardian (2) Email Address

_____

22. Parent/Guardian (2) Phone Number

_____

23. Parent/Guardian (2) Mailing Address

_____

Diagnosis Information

24. Diagnosis (Form of Cancer) *

_____

25. Treatment Facility/Facilities *

_____

_____

_____

_____

_____

26. Diagnosis Date *

_____

Example: January 7, 2019

27. Current Treatment Timeline *

Mark only one box.

- [ ] Newly Diagnosed (within the last 3 months)
- [ ] Ongoing Treatment
- [ ] Waiting for Procedure or Transplant
- [ ] Post Treatment
- [ ] Remission
- [ ] Recurrent Cancer

28. Estimated Treatment Completion Date

_____

Example: January 7, 2019

29. Does the patient travel out of state for treatment? *

Mark only one box.

- [ ] Yes
- [ ] No

30. If YES, Where do they travel to? (State/Facility)

_____

31. For gifts or experiences, please disclose best estimate for timeline of gifting. *

Mark only one box.

- [ ] Less than 3 months
- [ ] 3-6 months
- [ ] 6-12 months
- [ ] 12-18 months
- [ ] Other: _____

Demographic Information

* The following information is OPTIONAL to disclose and will not influence Baller Dream Foundation's selection process.*

32. How would you best describe yourself? *

Check all that apply.

- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Hispanic/Latino(a)
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White
- [ ] Prefer not to answer
- [ ] Other: _____

33. What is your annual family income? *

(Immediate family only)

Check all that apply.

- [ ] Under $36,000
- [ ] $66,000-$95,000
- [ ] $96,000-$125,000
- [ ] Over $125,000
- [ ] Prefer not to answer

34. Total number of people in immediate family of patient *

Check all that apply.

- [ ] 2-4
- [ ] 5-7
- [ ] 8-10
- [ ] 10+
- [ ] Prefer not to answer

Referring Agency/ Person Information

35. Referral Date *

_____

Example: January 7, 2019

36. I am referring... *

Check all that apply.

- [ ] Myself
- [ ] A Patient
- [ ] A Friend

37. What is your affiliation to the patient? *

Mark only one box.

- [ ] Non-Profit
- [ ] Physician
- [ ] Social Worker
- [ ] Certified Child Life Specialist or Child Life Team Member
- [ ] Cancer Survivor
- [ ] Past/Present "Baller"
- [ ] Baller Dream Foundation Staff
- [ ] Other: _____

38. Referring person's First & Last Name *

_____

39. Referring person's contact information. (Phone & Email) *

_____

40. Additional Comments: